**CLIENT INFORMATION FORM**

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| --- | --- |
| Client Name: | First Appointment Date: |
| Parent’s Name(s) (For Minors): |
| Address: | City: |
| State: | Zip: | Do we have permission to contact you at above address? Yes □ No  |
| Gender: Female Male | Date of Birth: | How did you hear about NACF? |
| Marital Status: Single □ Divorced □ Married □Widowed |
| Home Phone Number: |  | May we call you at this number? □ Yes □ No | May we leave a message? □ Yes □ No |
| Work Phone Number: |  | May we call you at this number? □ Yes □ No | May we leave a message? □ Yes □ No |
| Cell Phone Number: |  | May we call you at this number? □ Yes □ No | May we leave a message? □ Yes □ No |
| Email Address: |
| Emergency Contact Name: |
| Home Phone Number: | Cell Phone Number: |
| Religious Preference: | Church Attended: |
| Schooling (last grade completed): |

|  |  |
| --- | --- |
| Employment: | How long? |
| Were you referred for a work performance problem? □ Yes □ No |
| If yes, please indicate type: | □Absenteeism/ Tardiness |  □Safety/ Security |  □Work Relationships | □Quantity/Quality of work |  □Positive Alcohol/Drug Test | □Other |

**PERSON RESPONSIBLE FOR BILL**

|  |  |
| --- | --- |
| Name: | Relationship to Patient: |
| Address: | Employer: |
| Home Phone: | Cell Phone: |

**INSURANCE INFORMATION**

**YOU WILL NEED TO CALL YOUR INSURANCE COMPANY PRIOR TO YOUR VISIT TO ENSURE COVERAGE AND OBTAIN PREAUTHORIZATION NUMBERS**

|  |  |
| --- | --- |
| Name Of Provider: | Employer: |
| Name of Policy Holder:  | Policy Holder’s Date of Birth:  |
| Group Policy #:  | Insured ID #: |
| Address of Policy Holder if Different From Client: |

**\*WE WILL NEED COPY OF INSURANCE CARD\***

**MEDICAL INFORMATION AND RELEASE**

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| --- | --- |
| Recent Counseling Services (Where last seen): | Date last seen: |
| Medications (List all and reasons -Use back if more room is necessary: |
| Primary Care Physician: | Phone Number: |
| Date of Last Physical Exam: | Health: □ Good □ Fair □Poor |
| Any Conditions Relevant to Treatment? |
| Disabilities: | Okay to Contact Physician? □ Yes □ No |
| Any prior mental health diagnosis?  | When & where? |

**HEALTHY HABIT INFORMATION**

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| --- |
| Please base your answers on the past month: |
| Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit? □Yes □ No |
| Have you been dieting to lose weight? □Yes □ No |
| Have you smoked cigarettes on a daily basis? □Yes □ No |
| How often in the past month did you drink alcohol? □I do not drink at all □About once a month  □ 2 to 3 times a month □ 2 to 3 times a week □ Once a day or more |

|  |  |  |  |
| --- | --- | --- | --- |
| OPTIONAL: | Legal Issues □Yes □No | Financial Problems □ Yes □No | Military Service: □No □Past □Present Branch:  |

|  |
| --- |
| What Concerns Brought You to NACF?  |
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| What do you want to see happen as a result of coming here? |
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| What have you tried on your own to solve your concerns? |
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|  |

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission for NACF to contact my physician for medication clarification as indicated for treatment and to discuss my medical status.**

**I am aware that NACF uses psychotherapy practices from a Christian perspective. If you would like for your therapist to pray with you and/or provide you with Christian literature, please initial \_\_\_\_\_\_\_\_\_\_**

**By signing this document, I acknowledge that I have read this document carefully and know that I will be charged and will be responsible to pay for any no-show appointments and any amounts that are not covered by the insurance company.**

Signature **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**